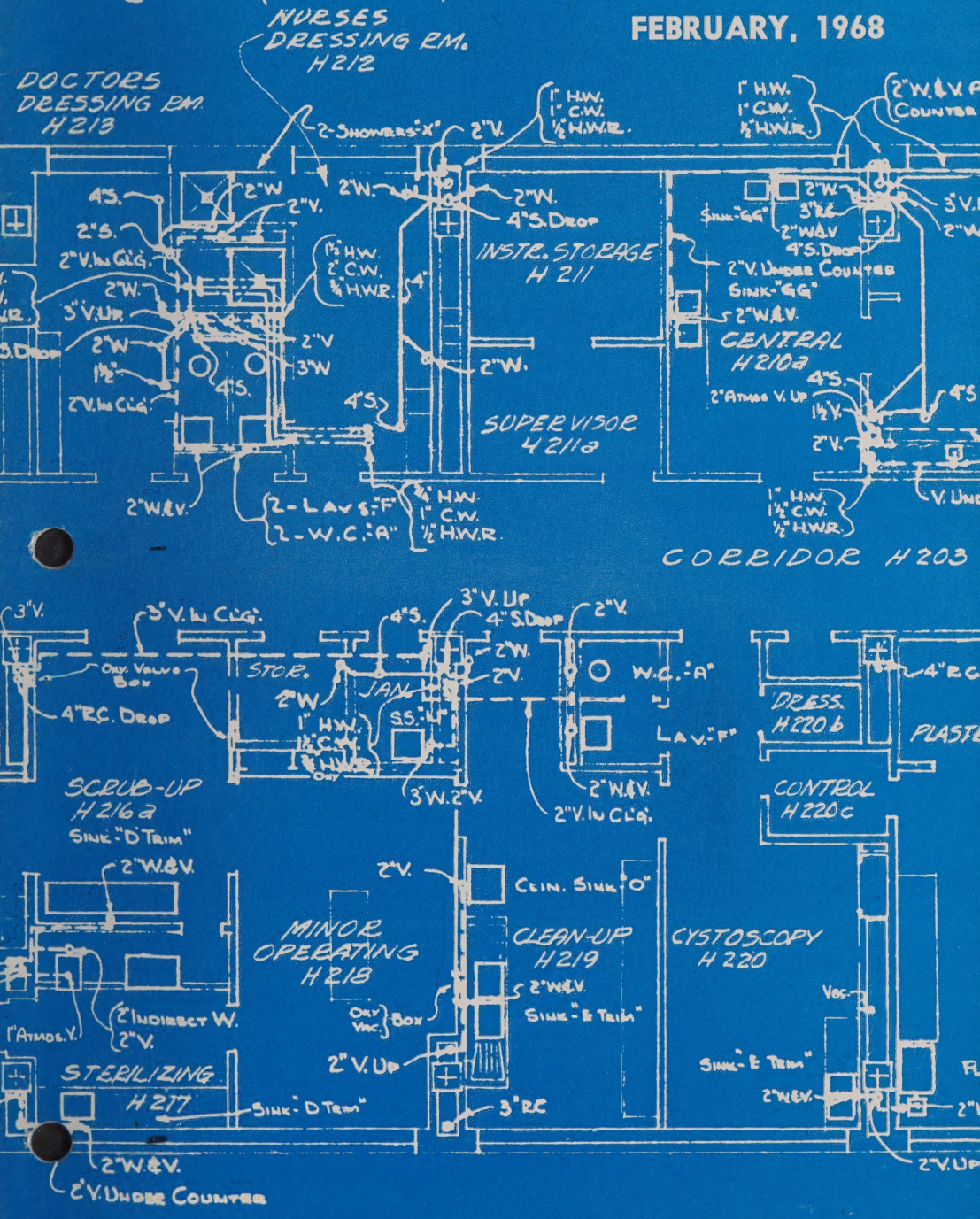
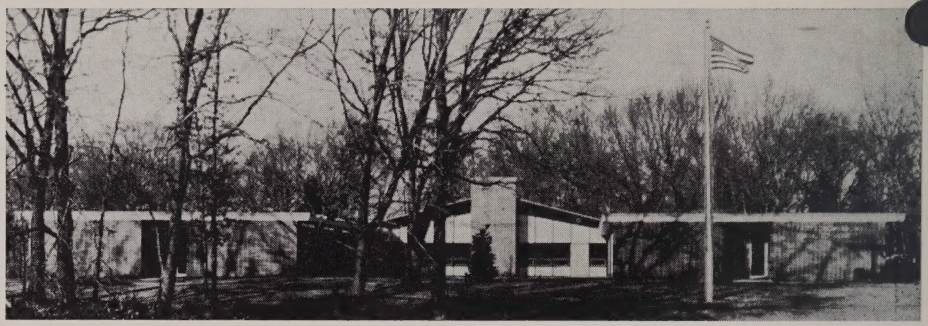
The Hampden Hippocrat

FEBRUARY, 1968



HOSPITAL CONSTRUCTION ISSUE



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EDITORIAL

Excelsior!

This issue of *The Hampden Hippocrat* is devoted for the most part to informing the profession about hospital construction in the District. Most, if not all, general hospitals in the area have just completed, are in the process of, or are planning some construction project. Moreover, these projects have been and are being entered into on the basis of studies carried on by each respective hospital with advice from hospital consultants of its own choosing and hire. This is the tradition of independent development which a large majority of the hospitals in this country have historically followed. Under such a system it could so happen that one hospital's plans would fail to consider the plans and programs of others serving the same area. This type of planning can give rise to imbalance and maldistribution of health facilities.

A basic principle of any economic institution is that its future may well depend upon its ability to compete in society. However, competition among hospitals is simultaneously denied and deplored. And yet, it must be admitted that this competitive situation often exists. The implications of competition are twofold. On the plus side, competition can and does yield a higher quality of patient care. On the other hand, competition may and does often lead to purchase or construction of unnecessary buildings, equipment, or services. The latter indicates inefficient and wasteful use of money, space, and personnel. It is the purpose and function of coordinated areawide planning to overcome the latter implication of competition and to plan in a logical and orderly fashion.

More cogently the need for coordinated planning of hospital and related health facilities and services has been brought about by such problems as rising hospital costs, the imbalance of various health facilities, obsolescence of existing facilities, limitations of financial support, shortages of skilled personnel, and vested interests of outside groups. To forestall any increase in these problems, coordinated areawide planning with an eye to providing "a high quality of health care, efficiently organized, economically provided, community oriented, and with continuity of care assured" is a must.

How is this planning process to become a reality? There are those who maintain that the voluntary way based on education and persuasion is the best approach, and there are those who espouse governmental regulation and enforcement as the only effective means. With the recent incorporation of the Connecticut Valley Health Planning Council, our area is about to try the voluntary way. Although conceived, gestated, and given birth to by local hospitals, this new planning agency is committed to achieving good balance with broad community representation in leadership and health professional participation. "The real protagonists of effective hospital and health planning must come, to a large extent, from the ranks of the medical profession and from influential and responsible community representatives" if the future strength and freedom of our voluntary health system is to survive. It is most likely that government intervention in areawide health planning in the future will be in direct proportion to the degree of failure of voluntary groups to develop and implement effective plans.

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THE SPRINGFIELD

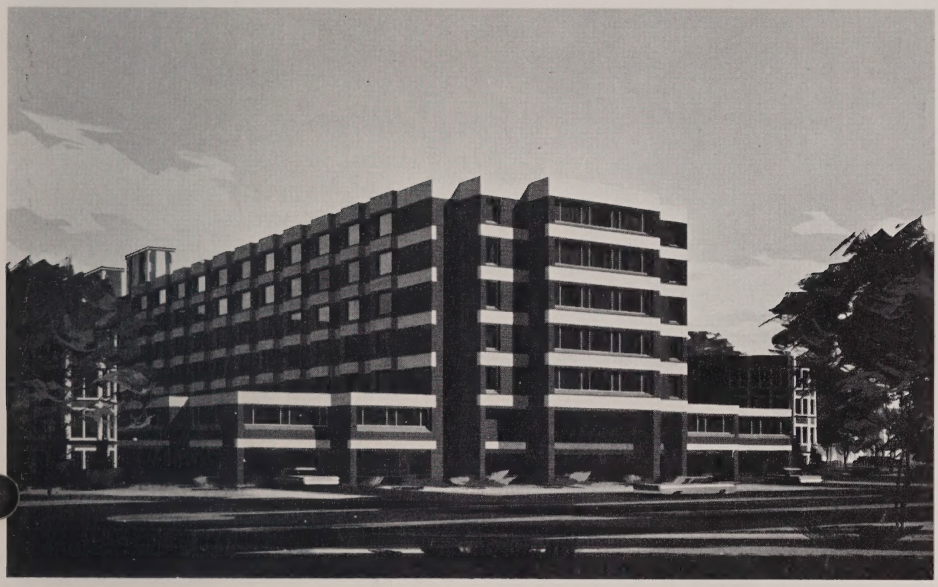
Phase I — North Wing

An ambitious expansion program will bring the bed capacity of the Springfield Hospital to about 610 beds by 1973 and will cost about 9½ million dollars if present construction plans go well.

The first phase of the building program calls for construction of the North Wing. This will consist of five stories as indicated in the architect's sketch. An entire new rehabilitation area is planned for the ground floor, providing for physical therapy including hydrotherapy, occupational therapy, and speech therapy. On the first floor, a completely new emergency room is planned. Also on the same floor will be an admitting unit with a 20 bed holding unit. In this unit, patients coming into the emergency during the night may be held over night, either for discharge home in the morning, or, if indicated, for admission into the main hospital. The remaining three floors will be for extended care facilities, and will contain 38 beds on each floor. In addition, provision is being made for the addition of three additional floors at a later date if this should be needed. The entire wing will have central air conditioning. Ground breaking is planned for this coming summer, and construction will require about two years. The cost of this phase of the building program is estimated to be about 3 million dollars.

After this North Wing is completed in 1970, the second phase of the construction program will begin. This phase will consist of a major addition

HOSPITAL ...



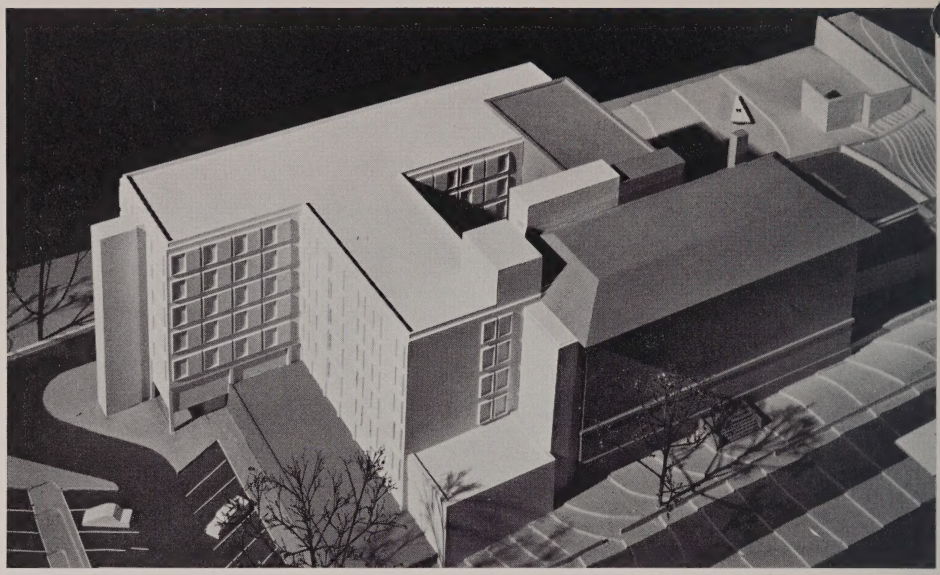
Phase II — Central Wing

to the front of the Hospital, filling in the large area between the present Chapin and Wright Wings, and will contain an entirely new main entrance on the ground floor. This building will be connected on three sides with the older building. In addition to the new main entrance, the first floor will contain a new lobby, coffee shop, gift shop, a new admitting area, administration and business offices, and data processing areas. The personnel office will occupy the area now used by the laboratory in the Chapin Wing. The Out-patient Department will remain in its present location, but will be expanded into the area now used for the emergency room.

On the first floor, a whole new laboratory and pathology department is planned. Also on this floor will be new operating rooms and recovery suites. Above this floor will be three patient floors planned for 22 single rooms per floor. The accompanying photograph depicts five such floors, although only three of these floors are planned initially, with provision for vertical expansion at a later date. Construction of this wing will start in 1970 after the North Wing is completed. This wing called the Central Wing will require about 30 months to complete and will cost about 6½ million dollars.

All of the new construction units will have central air-conditioning. Eventually, air-conditioning will also be installed into the older building, with one central air-conditioning unit for the entire hospital.

WESSON MEMORIAL HOSPITAL



Shown in white are an eight-story wing and six-story addition to the present service building which are currently under construction as part of Wesson Memorial Hospital's expansion and modernization program.

Springfield's Wesson Memorial Hospital has begun construction on its $8.8 million expansion and modernization program, which is scheduled for completion in 1970. Work is already underway on an eight-story wing at the rear of the Hospital, and a six-story addition over the present service building.

The Hospital's expansion program resulted from adoption in 1962 of a 10-year master plan for development based on recommendations by hospital planning consultants following an intensive study and survey of Wesson's present and long-range needs.

Completion of the total project will see:

1. The replacement of 160 beds for medical and surgical patients. These beds are now in Wesson's older buildings and will be replaced by new equipment of the latest design.

2. The addition of 100 patient beds in new private and semi-private rooms. This will bring the Hospital's total number of beds to about 369, from the present 269, and will enable Wesson Memorial to care for approximately 4,000 more patients each year.

3. Enlargement of medical-surgical, orthopedic and pediatric units, and new intensive care and cardiac intensive care units. The most effective and modern cobalt unit for deep therapy is to be installed. A start has already been made in the planning of a tumor registry for correlation of factors in diagnosis, treatment and follow-up of patients with malignant disease. Pioneer work in isotope use and mammograpy for earlier detection of malignant disease has improved the level of tumor diagnosis and treatment.

4. Creation of a physical medicine department.

5. The expanded emergency department, which will be ready this spring, will be three-and-a-half times its present size to meet the volume of emergency service which has increased by 670 percent in the last decade.

6. The outpatient department will be expanded to eight clinics for both

private patients and those who receive treatment under Medicare and Medicaid.

7. Other departments that will be enlarged to meet present demands and those of the foreseeable future include: laboratory, pathology, deep therapy, admissions, medical records, housekeeping and maintenance, the business office, and the laundry.

8. In addition to the full scope of X-ray diagnostic facilities, the Hospital's plans also call for a complete cancer therapy center for both in-patients and out-patients.

The Hospital has already acquired cardiac pacemaker alarm-monitors and resuscitation equipment for the cardiac intensive care unit and conducted a training program in its use for professional personnel. The treatment program made possible by the monitoring and resuscitation equipment is called "the most exciting medical advance in this generation" by Dr. Myles H. Illingworth, who heads the committee planning the new cardiac intensive care unit. "This is the first time we have been able to do anything to prevent sudden deaths in patients suffering acute coronary attacks," he said. During the past year more than 500 persons suffering coronary heart disease were admitted to Wesson Memorial alone.

Nearly $2 million has been raised to date from a community fund drive for the larger and more modern hospital. Hospital President Graham King has announced that a special committee of trustees and corporators under the chairmanship of Allan A. Campbell will continue its efforts in the upcoming months to raise an additional $300,000 to meet the established goal of $2¼ million.

"The new facilities being provided at Wesson Memorial Hospital are vital to the community," Mr. King said, "and it is important that we close the dollar gap and reach the original goal of $2,225,000. I am confident that we have the desire and ability to accomplish this objective."

The balance of the $8.8 million needed for the building program will come from the Hospital itself, $2 million; a federal grant announced last June, $450,000; and a mortgage loan issued by Massachusetts Mutual Life Insurance Co., $4.1 million.

Daniel O'Connell's Sons, Inc. of Holyoke is the general contractor, and James H. Ritchie and Associates of Boston are the architects and engineers for the project. Construction will be completed in stages so as to cause a minimum of disruption in the operation of the Hospital.

"The new facilities now under construction should allow us to provide as new and as sophisticated medical and health services as the community may need and demand," Mr. King stated.

Wesson Memorial Hospital, founded in 1906, cared for over 10,500 patients last year, with an average occupancy rate of 90.3 per cent. Emergency room visits increased by 14.3 per cent over the previous year to 33,000.

The Hospital annually serves a quarter of a million meals, performs 153,000 laboratory tests, and fills 150,000 prescriptions in its pharmacy. Wesson has over 600 employees, with an annual payroll of more than $2 million.

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THE MERCY HOSPITAL

Mercy Hospital, Springfield, is planning the construction of a 400-bed hospital, to be erected on a site adjacent to the present hospital buildings. Acquisition of surrounding properties to bring the total hospital area to 35 acres is now under way.

The architectural firm of Westermann and Miller of New York City is preparing the preliminary drawings for the new Mercy Hospital and it is anticipated that construction will get under way in 1969. Cost of the new hospital has been estimated at $12 million.

Upon completion of the new hospital the older building of the existing hospital will be razed while the relatively newer portion will probably be utilized as an extended care facility.

Mercy Hospital was founded in 1896 and incorporated on February 2, 1898, "for the purpose of establishing and maintaining a hospital in the City of Springfield for the purpose of furnishing medical and surgical treatment for persons requiring the same."

The hospital is presently a 302-bed acute general hospital that is providing a comprehensive program of inpatient and outpatient services to the population of the Greater Springfield area.

It provided 91,174 patient days of care to the 10,252 patients admitted to the hospital during fiscal 1967, with an additional 18,423 outpatients being treated. It employs more than 890 full and part-time employees, with an annual payroll amounting to more than $3.2 million during the past fiscal year.

It spent more than $1.2 million in supplies and equipment during the past year, most of it within the Greater Springfield area.

The Hospital operates a school of nursing which graduates approximately 25 highly skilled registered nurses each year. The Hospital also operates a school of anesthesia, a school of radiologic technology, and a school of medical technology that is affiliated with the College of Our Lady of the Elms and the University of Massachusetts.

Mercy Hospital also is affiliated with the Springfield Technical Institute in the training of licensed practical nurses, physical therapy assistants, inhalation therapists and surgical technicians.

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For brief summary of prescribing information, see reverse side.

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Warnings: Administration to patients with central nervous system disease, particularly geriatric patients with cerebral arteriosclerosis, and patients with a history of epilepsy or other "seizures", requires strict observation for possible untoward effects (see Adverse Reactions). Patients taking psychopharmacologic drugs, central nervous system stimulants, or alcoholic beverages should be observed for possible evidence of intolerance. Those patients who experience central nervous system effects or blurring of vision should be cautioned against driving or working in situations where alertness is important.

No teratogenic effects have been seen in reproductive studies in rats and rabbits. Studies in pregnant women have, however, not been done and use of this drug in women of childbearing age should be undertaken only after weighing the possible risks to the fetus against benefit to the pregnant patient. It should not be administered to nursing mothers since it is not known whether the drug is secreted in the milk.

Precautions: Ineffective against bacterial infections. Patients should be observed for idiosyncratic reactions as with all new drugs. Geriatric patients with pre-existing serious medical illnesses with mental or physical deterioration should be followed carefully while taking "Symmetrel". (See Adverse Reactions.)

Adverse Reactions: With higher than indicated doses manifestations of central nervous system effects such as nervousness, insomnia, dizziness, lightheadedness, drunken feeling, slurred speech, ataxia, inability to concentrate and some psychic reactions including depression and feelings of detachment were seen. Occasional blurred vision was reported at higher doses. Some of the milder a[nd] less pronounced symptoms above ha[ve] been reported in a small number of patients taking the recommended dosage of 200 mg per day. These were mostly transient and disappeared with continued administration of the drug. Some geriatric patients developed paranoid or hallucinatory behavior and became unmanageable while taking 200 mg daily. Medically unselected seriously deteriorated geriatric patients showed poor clinical tolerance after several weeks of daily dosing with 200 mg per day. One elderly patient with a history of prior cerebrovascular accident developed visual hallucinations and grand-mal convulsions while on the drug at 800 mg per day. Some cases of dry mouth, gastrointestinal upset and skin rash and, rarely, tremors, anorexia, pollakiuria, and nocturia have been also reported.

Dosage: Adults: Two 100 mg capsules (or 4 teaspoonfuls of syrup) as a single daily dose; or the daily dose may be divided into one capsule of 100 mg (or 2 teaspoonfuls of syrup) twice a day.

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HOLYOKE HOSPITAL

Current status of the Holyoke Hospital showing on the right the new wing; in the center, the 1951 wing; to the left of center, original building constructed at the turn of the nineteenth century; extreme left, the Skinner Clinic and School of Nursing.

Approximately one year ago the Holyoke Hospital opened a new two-story wing providing 106 medical and surgical beds with a 13 bed intensive care unit, a 23 bed pediatric dept., a 13 bed recovery room, a new physical therapy dept., and expanded, modernized laboratory and radiology facilities.

The construction program also included remodeling of the first and second floors of the existing building for the purpose of centralizing the dietary dept., remodeling the cafeteria, renovating the surgical suite, and expanding the business and administrative offices. Parking facilities for the public and employees were increased from 155 spaces to more than 300; moreover, the front driveway was redesigned to expedite all traffic. The total cost for this phase of the Hospital's development program was in excess of 3 million dollars.

During the past year the older wing of the Hospital has been remodeled floor by floor and is now in full operation thereby giving the Hospital a bed capacity of 308 beds. The basement of the new wing is currently being finished off and will house laundry facilities, central supply, and a general storage area. The latter phase is costing $400,000.

Plans for adding a third, fourth, and fifth story onto the new wing are under consideration and may be implemented in the not too distant future.

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THE NOBLE HOSPITAL

The Noble Hospital in Westfield finds itself at a point where it must, once again, look ahead to additional expansion. During the past ten years this hospital has expanded from a 70 bed institution to its present 154 bed facility. As a general hospital with maternity in a rapidly growing community, the Hospital finds that increasing demands are being made upon it for all general services with the greatest pressures being exerted in the emergency room department, the medical-surgical bed facilities and outpatient facilities for laboratory, X-ray, and physical therapy services. A master plan has been developed to assist the hospital in planning its expansion. This master plan indicates that Noble Hospital, during the next five years, should provide approximately 200 beds for its area. Various phases of development are provided for in the master plan: phase 1 being an addition to the ancillary facilities and phase 2 being the creating of additional beds. The first phase, which would involve laboratory, dietary, and X-ray expansion, is estimated to cost approximately $1,000,000. No definite starting date has been established at this time.

PROVIDENCE HOSPITAL

Since the new Providence Hospital complex opened almost ten years ago, new and additional construction planning has been relatively at a standstill and particularly in the light of pending decisions and plans relative to the Mercy Hospital in Springfield. However, preliminary planning is now underway to build an addition for housing an expanded radiology dept., for providing additional and much needed storage and office space, and for furnishing facilities to a resident Chaplain. In addition, it is contemplated to install during the coming year an automatic standby generator for the Hospital's power plant. Although the Hospital is adequately covered by an emergency generator, the latter does not serve the 3 large boilers of the power plant thereby requiring manual operation in the event of power loss.

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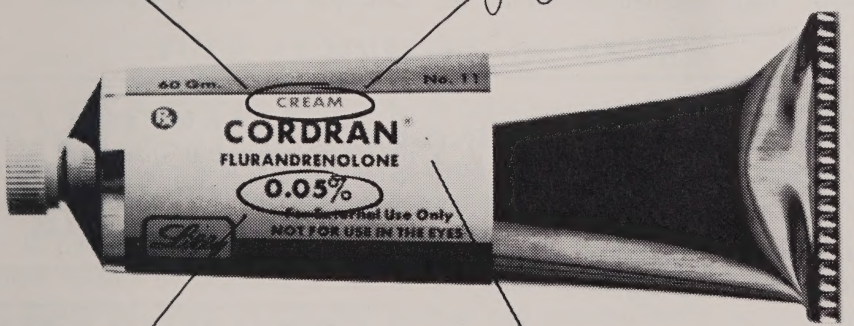

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MARY LANE HOSPITAL

Mary Lane Hospital in Ware, in company with similar institutions all over the country, is taking a long look at its existing facilities and charting what changes and additions are required to help meet the increasing demand for hospital services.

While a sub-committee of the hospital board has for many years been charged with long range planning and plant improvement, increasing pressures of recent years have caused Directors to retain the services of experts in the hospital planning field. In 1963, a detailed study by the James H. Ritchie Associates was carried out and their recommendations duly noted. Within the past year, the Directors authorized expenditures of funds for further studies and plans. Markus and Nocka, Inc., hospital consultants of Boston, are currently conducting a study, and a detailed review of Mary Lane Hospital facilities and needs is expected in the near future.

With their recommendations in hand, the hospital board will implement plans for a long range program to make maximum use of existing facilities, to provide economical expansion to overcome present deficiencies, and to meet the future needs of the community.

Among major plant improvements contemplated is the construction of a three story building between the present Storrs and Gilbert Wings. Such construction would permit inclusion of a badly needed surgical complex, including operating and recovery rooms, new quarters for emergency services, and a centralized section for ancillary services.

Such a program as described above, which would cost in the neighborhood of $800,000 according to an earlier estimate, would permit the addition of more surgical beds and the development of the Gilbert Wing as a combination convalescent and long-term care unit, as originally planned.

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WING MEMORIAL HOSPITAL

Plans for two separate building projects on the grounds of Wing Memorial Hospital in Palmer will result in a one-story community health center and a three-story addition to the Hospital, which will be known as the Dornoe Parker wing.

Construction of the Parker wing is expected to begin in 1969 and follows several years of study as to how funds from the Parker estate could best be spent to meet the medical needs of the area served by the Hospital. The addition which will cost over one half million dollars, will enable the Hospital to increase its bed capacity from 85 to over 100.

The new wing will house the kitchen and cafeteria, a medical storeroom, physical therapy room, pediatrics department and 20 to 30 additional adult beds. The possibility of setting up an intensive care unit there is also being investigated.

In addition to the planned wing, the Dornoe estate recently made possible a modern, enlarged six-bed recovery room which was opened in 1967.

The community health center will be financed by the Hospital and staffed by a group of doctors known as Wing Medical Associates and headed by Dr. Harry J. Anton, President of the Wing Memorial Hospital Medical Staff, who will conduct their private practices in the new facility. Construction of the new facility will begin shortly with completion scheduled for early summer.

YOUR COMMITTEE OF CHOICE

In order to insure the widest possible participation in the H.D.M.S.'s affairs, I am hereby inviting and urging members who have a particular interest to name the committee on which they would like to serve. Needless to say, the effectiveness of a committee is in direct proportion to the interest and concern of its members.

In the forepart of the *Hippocrat* is a complete listing of the Society's committees. Simply by dropping a note or calling the H.D.M.S. office at 1414 State St., Springfield, Mass. 01109, your interest and preference will be given most serious consideration for appointment. Moreover, you will be rendering a distinct service to your profession, your community, and your Society.

Committee work is the heart of any organization. I urge you to let us know where you wish to apply your talents and energies.

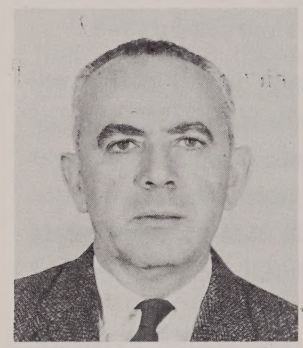
Vice President and President-Elect
Wayne C. Barnes, M.D.

The next meeting of the

SPRINGFIELD ACADEMY OF MEDICINE

will be held on

TUESDAY, MARCH 12, 1968, at 8:30 P.M.



SPEAKER: FRANCIS F. FOLDES, M.D.
Chief, Division of Anesthesiology
Montefiore Hospital, New York

TOPIC: "NARCOTIC POISONING"

PLACE: Auditorium, Municipal Hospital, Springfield

CLINIC: Wesson Memorial Hospital, 5.00 P.M.

MARK YOUR CALENDAR NOW!

HDMS ANNUAL MEETING, APRIL 23

HDMS Executive Committee Meetings, March 19 and April 16

MMS Council Meeting, Boston, May 20

MMS Annual Meeting, Boston, May 21-23

New England Hospital Assembly, Boston, March 25-27

AMA Second National Congress on the Socio-economics of Health Care, Chicago, March 22-23

American Psychosomatic Society, Boston, March 29-31

American College of Physicians, Boston, April 1-5

AMA Annual Meeting, San Francisco, June 16-20

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ACADEMY, WHITHER GOES'T?

by OMAR T. PACE, M.D.

Board of Directors, Springfield Academy of Medicine

Over the last several years many of our doctors have given serious thought as to the role, function, and future of the Springfield Academy of Medicine. Many divergent conclusions have been reached, but no real solutions offered. There is no question that over the years the Academy has played a very useful and vital part in the medical life of Springfield. Many of us feel that it, with its library, still can and should play an active and useful role. There is no doubt that with the changes in post-graduate education, hospital programs, etc. the Academy must likewise change. There is now before the Springfield Academy of Medicine an offer from the Springfield Technical Institute that could well initiate such a change. As one who has sat in on all the preliminary meetings, I would like to present some background so that we might all evaluate this vital proposal.

The Springfield Technical Institute concept evolved from 10-15 years of post graduate technical courses of and at the Trade High School. Because of real needs and good guidance, it has flourished and expanded. It is now occupying the Springfield Armory Square which is an ideal campus for its mushrooming student enrollment, courses, and excellent staff under the guidance of Mr. Edmond P. Garvey and Mrs. Theresa Thompson. It is now a fully approved community college offering associate degrees and courses for medical laboratory assistants, surgical technicians, practical nurses, physical therapy assistants, medical assistants, dental assistants, inhalation therapists, dental processing technicians, bio-medical instrumentation technicians, and others. Even now, as you look about, you find many of these students and graduates in laboratories, doing EKG's, in medical records, in nursing, in doctor's offices, etc. These will be the people running and fixing our monitoring equipment, scanners, computors, etc. These paramedical people are becoming more and more a vital part of our medical team. Now is the time for the medical profession to encourage them in every way possible.

THE OFFER

1. Basically the offer is to house the library of the Springfield Academy of Medicine on the latter's terms. The Institute readily admits that it needs a library, that the Academy's library is good, and that most would agree it would lend some prestige. I am sure the Institute can put a bill into the Legislature for many thousands of dollars for a library which we as major taxpayers would have to pay for. Many have said that our library would be too sophisticated and of little value to the Institute. The fact is, however, that this facility has been by far the largest users of our library over the recent years.

2. The Institute offers room which it has plenty of at this time. The library would be housed in the present Armory Gun Museum. The Academy library would be in its own designated area, separate from the Institute's if such is our wish. Quiet stacks and reading rooms will be available; all of which we do not have now. If the Academy's library goes into a regional program in the near future as it is hoped for, it must have more space

which is not available at the present location but will be at the Armory.

3. The Institute offers a place to hold any and all of our meetings if we wish. At present it would be at the Officers' Quarters' Building which will accomodate 75 with eating and drinking facilities available. This might be a more effective illusion for our speakers than the present audiences of 50 to 70 trying to fill a fine but very large auditorium. The Institute feels that it is a community college dedicated to aid in community education in any way possible. In the future it hopes to have a much larger auditorium available for special events.

4. The Institute offers a much more central location. It is closer to all of the hospitals and to the majority of the doctors' offices. It has ample parking.

5. The Institute has a library budget. Of course, it is not going to finance the Academy's library, but it does offer help with some journals and librarians. It has two full time certified librarians which will help in all areas. It realizes our present "girl Friday" spends part of her time as secretary to the Academy. The Academy will continue to have and pay for this. However, the Institute will have her remain with our library and pay her as a part time librarian assigned to us. We will keep our Library Committee on a permanent basis to select our books and journals as in the past, and these will not be relegated to quasi-medical books. The Institute will welcome guidance in this area.

6. The Institute offers us complete autonomy. We can write our own rules and stipulations to make this legal and permanent. It has no desire to take over or absorb the Academy. In fact, I suspect for the Academy of Medicine to lose its identity would defeat some of the value and purpose of the move.

7. The Institute offers association with a fine highly trained technical staff. Their instructors and professors are a benefit to the community and medical profession. They can be of tremendous aid to us collectively or individually in special projects or in hospital work. We should ally ourselves with them in every way for mutual aid.

The present offer and issue deals only with the library; however, in time many mutual idea sand programs could be developed. The Academy might develop active advisory or coordinating programs with these skilled people developing paramedical personnel that we desperately need. This could eventually develop into almost a medical school atmosphere with mutual stimulation.

DRAWBACKS

1. Many of us are reluctant to leave the Municipal Hospital which has been a most generous and kind host for the past 13 years. The Municipal Hospital, I am sure, will miss the library and the Academy. However, they do have their own basic hospital library. Changes are inevitable. No one knows the future role or status of the Municipal Hospital. We are there on a year to year basis at the pleasure of a few friends. With the Commonwealth assuming responsibility for welfare aid, it may have something to say as to the use of the Hospital's space. It is rumored that the Commonwealth may take over the Hospital. Thus, should the Academy move or not move, it could well be that the Commonwealth would still be our landlord. Most will agree that at the present time government seems to be more kindly disposed to educational situations rather than to strictly medical environments.

2. For years the Academy has suggested an affiliation with the Hampden District Medical Society. This year's president, Dr. Joseph Baker, who was

an illustrious and devoted Secretary of the Academy and Dr. Fisher have developed a joint committee to look into the matter. All of the members of the Hampden District now already support the Countway Library in Boston. I know the many members outside of the Springfield area are not anxious to support another. Even an extra assessment of the members (i.e. - $5.00 × 500 = $2,500) would not solve the Academy's financial problems. Nor can one demand 100% membership in the Academy. Neither will these solve the basic problems of interest in the Academy's functions and utilization of the library. The most beautiful and complete library that collects dust is a total failure. The books are meant to be used and are worthless if not. As a recent Academy President, I know there are many with grave doubts as to the future of the Academy. It could well wither away, especially, if we do not take positive steps and take them soon. The Springfield Technical Institute is now teaching students. It needs a library and cannot wait indefinitely. The Academy must make up its mind soon.

3. One of the greatest fears of many seems to be that the Springfield Academy of Medicine will be swallowed up and lose its identity if it moves. This certainly is not the intent of the Institute, for it will let us take any legal steps to prevent this. We will have a separate area in the overall library and be appropriately so designated. We will still have a permanent Academy Board, etc. This fear was also rumored in 1959 when we moved up to the Municipal Hospital and certainly it has never been a problem. Most important, as previously noted, if we don't do something we may lose our identity with anything. This would be an inglorious ending for an organization that has meant and done so much in Springfield.

I think this offer, thus, has tremendous potential for the future of the Academy, and for us as physicians to help, perhaps to guide, and to cooperate with a much needed and valuable allied group.

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MORTALITY STATS

An unofficial analysis of death certificates filed for Springfield residents in 1967 reveals that a total of 1,659 persons died during the year. This figure does not include those Springfield residents whose deaths occurred outside of the City nor those deaths occurring in the City for non-residents thereof.

The ten leading causes of death were:

1.	Diseases of the heart	684
2.	Neoplasms	278
3.	Cerebrovascular lesions	199
4.	Pneumonia (all types)	93
5.	Accidents	74
6.	Cirrhosis of liver	55
7.	Bronchitis	41
8.	Diseases of early infancy (Under 4 weeks of life)	33
9.	Gastritis	15
10.	Suicide	15
	All other causes	172
	Total	1,659

Deaths from heart disease lead the list with 41.2%; next, cancer with 16.8%; third, cerebrovascular disease with 12%; and fifth, accidents with 4.5%. Approximately 77.6% of the deaths were amongst those sixty years of age and above. Females predominated over males in the ratio of 1.06 to 1. As in the recent past, these mortality statistics point up the fact that chronic diseases, particularly those of the cardiovascular system are the major health problems in Springfield.

Deaths from infectious diseases during 1967 were due to:

Pneumonia	93
Bronchitis	41
Meningococcal Infections	1
Meningitis	3
Tetanus	1
Tuberculosis	1

Only 6 deaths were due to diseases considered officially dangerous to the public health. Most of the pneumonia and bronchitis deaths were undoubtedly fatal superimpositions upon some other prolonged, debilitating disease processes.

The case of infectious diseases reported officially to the Health Dept. in 1967 were:

Chickenpox	75
Dysentery	2
German Measles	6
Hepatitis	20
Measles	2
Meningitis	13
Mumps	115
Salmonella	32
Scarlet Fever	42
Strep throat	531
Tetanus	1
Tuberculosis	21
Whooping cough	4

Although there is obviously an underreporting of the common communicable diseases of childhood, it is quite gratifying to note the low incidence of infectious diseases for which there are effective immunizing agents.

Analyzing the 74 deaths occurring in 1967 as the result of accidents, some interesting facts come to the fore. First of all, 48 occurred in the home, were due to falls, and involved 17 men and 31 women with all deaths but 2 occurring in those 50 years of age and above. Secondly, 13 persons were killed as the results of traffic accidents — 6 drivers, 1 passenger and 6 pedestrians. Four persons died of burns. One death resulted from each of the following: ingestion of poisonous berries or mushrooms, aspiration of bath tub water, a blanket wrapped around the neck of an infant, carbon monoxide poisoning, ethanol intoxication, expos-

ure to cold, severe lacerations in an industrial plant, and a sensitivity (allergy) reaction.

Looking at mental health connotations, it might be noted that there were 15 suicides (7 males and 8 females) with deaths beginning in the 10-19 year age group and occurring in each ten year grouping reaching a maximum of 5 in the 40-49 year old grouping and continuing into the 80 plus group. Moreover, there were 9 homicidal deaths — 4 males and 5 females.

There were 2 deaths resulting from complications of pregnancy (maternal deaths) and 24 stillbirths were reported. Sixty-two infants (under 1 year of age), died with 33 being due to certain diseases of early infancy (prematurity), 10 due to pneumonia, 10 due to congenital malformations, 5 due to bronchitis, and one each respectively due to diseases of the circulatory system, accidental strangling, homicide, and ill-defined causes.

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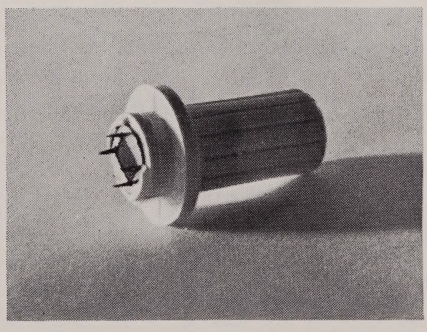

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MANDATORY IMMUNIZATIONS FOR SCHOOL CHILDREN

On December 4, 1967, a new law went into effect within the Commonwealth of Mass. requiring all school children to be immunized against smallpox, diphtheria, tetanus, pertussis, measles, and poliomyelitis, unless exempted for medical or religious reasons. A *school child* referred to in the law is any student attending *public or private school from kindergarten through grade eight.* It does not apply to high school, college or post-graduate schools.

On December 4, there were many children attending school who had not completed their immunization requirements and who did not fall into that small group exempted from compliance because of medical or religious reasons. Also, at the beginning of each school year, there will be many new students registering without certificates of immunization. It cannot be over-emphasized that it was never intended that any child whose parents comply with the intent of the law should be excluded from school for even a single day. For example, a note from a private physician that he has started the immunization of a student, represents adequate evidence of compliance. There will be a few children who have been immunized or who have had measles, but a medical certificate cannot be obtained for one reason or another, such as the death of the physician, the parents did not call a physician in the case of measles, etc. In instances of this sort, a statement from a parent or guardian is acceptable in lieu of a physician's certificate.

After the age of six, pertussis vaccine is medically contraindicated. Therefore, all students over six years of age are exempted from receiving pertussis vaccine. Similarly, a student who has had measles is immune by virtue of having had the disease and does not need the vaccine.

In the instance of measles vaccination, inactivated measles virus vaccine should not be used because the immunogenic response as well as the protective capacity are less effective than that of the live attenuated measles virus vaccine. Morover, even more important, recent reports have documented the occurrence of unusual and disturbing local and systemic reactions in children previously immunized with inactivated virus vaccine. These reactions were provoked either by exposure to natural measles virus or by innoculations of live virus vaccine. A dilemma is presented by children who may have received only inactivated virus vaccine in the past. Since the severe, generalized disease resulting from exposure to natural measles in children immunized previously with inactivated virus vaccine is more debilitating and less acceptable than the milder reactions with live, attenuated measles virus vaccine, it is generally recommended now that children who have been given inactivated measles virus vaccine should also be given live vaccine for full and lasting protection against natural infection.

There will be a small group of children exempted from the law because of medical or religious reasons. In the case of the former, a statement from the family physician is required indicating the reasons why one or more of the immunizations should not be given. In the case of a religious exemption, a certificate must be completed by an official of the church or religious denomination.

Ayres

CORRESPONDENCE

THE NEW MASTER MEDICAL PLAN

To the Editor:

It is with great fanfare that Blue Shield is announcing to us — the participating physicians — and to the public that starting in February they will pay "usual and customary" fees.

After many years of fighting and under great pressure from the Council within the past year, including a threat from some groups to resign from Blue Shield, Blue Shield is now throwing us a bone nicely gift-wrapped with a pretty bow on it. However, if we unwrap this package and look at it closely, we will find that it is only a bone with no meat on it.

Let us take a good look at this "major breakthrough" as Blue Shield called it in a letter to all participating physicians dated Jan. 4, 1968.

According to one of the directors of Blue Shield, the "usual and customary" fee will be arbitrarily set by Blue Shield as Plan B plus 30%. Alledgedly, this is the result of the survey conducted in recent years.

Now let us take the fee for an appendectomy, which under Plan B Blue Shield is $125. Adding 30%, (i.e. Blue Shield's "usual and customary" fee) it would be $162.50. Of this, they will pay us 80%, which would be $130. We shall, therefore, under this new scheme be paid $5 or 4% more than before.

Moreover, they have come up with another even more serious insult. Far from doing away with service benefits contracts as requested by a resolution of the Council last May, they are *expanding* service benefits contracts to *over-income* subscribers, and they have announced this in the same letter quoted above: '. . . payment for over-income members will be 95% of usual and customary charges (i.e. Plan B, plus 30%), *which will represent payment in full.*"

It seems almost unbelievable that such a practical joke could be perpetrated upon us, namely, an increase of all of 4% in their fees in a selected group, coupled with an extension of service benefits contracts to over-income patients!

I sincerely hope that the Executive Committee of our District Society will take this matter up immediately and will instruct our Council delegation to strongly oppose this issue at the next Council meeting.

The crucial point to be ascertained, of course, is Blue Shield's definition of "usual and customary" charges. If it is true that this will be fixed at Plan B plus 30%, we should never accept this scheme.

Karel J. Susat, M.D.
Holyoke, Mass.

Dr. Susat's letter was referred to the Mass Medical Service, which offers the following reply:

To the Editor:

After reading Dr. Susat's letter, I am impressed with the fact that it is charged with some emotionalism and interspersed with misunderstandings and inaccuracies.

There are nine paragraphs in Dr. Susat's letter, and I will comment on each separately.

In the first paragraph, he refers to "great fanfare." This statement refers to a simple announcement sent out by the Blue Shield Office to practicing physicians stating that in February a contract will be made available to the larger groups in the State which will pay fees based on the usual and customary fees of physicians. This action was taken with the approval of the Board of Directors of Blue Shield and the Blue Shield Voting Members (Executive Committee of the Massachusetts Medical Society).

In the second paragraph, he refers to many years of fighting without identifying those who were fighting. It is true that over a six year period, the Committees representing the Medical Society and Blue Shield were faced with a series of frustrations in their attempt to get an increase in an antiquated fee schedule. As is well known, the Commissioner of Insurance refused to approve an increased fee schedule and Blue Shield took it to the Courts where they were finally defeated. This took all of a year and a half and during this period, the Commissioner obviously would not act on any new fee schedule. Following this, Blue Shield and Blue Cross were studied by a Commission of the State Legislature. Again, the Insurance Commissioner refused to act on a new fee schedule until the Commission finished their report. This consumed another two-year period. Following this, the Corporation was told that with the impending Medicare legislation, a revision of the fee schedule was unrealistic and would not be considered until it was determined how much money Blue Shield would save shifting the poorer and older risk subscribers from the Blue Shield contract to the Medicare contract. After this actuarial experience was available, the Commissioner finally consented to approve a modest increase in the Plan B Blue Shield fee schedule. In the same paragraph, Dr. Susat refers to the threat of physicians resigning from Blue Shield. To my knowledge, no physician has handed in his resignation.

Paragraph three requires no comment.

Paragraph four states that usual and customary fees will be arbitrarily set by Blue Shield Plan B plus 30%. This is an inaccuracy and probably refers to the action taken by the Council when they voted to approve Blue Shield Plan B plus 30% as an emergency fee schedule to be used by the Department of Public Welfare for Medicaid patients for a limited period only. There has never been any reference to using Plan B plus 30% as payment for usual and customary fees under the new contract being sold to the larger groups. Actually, usual and customary fees are not set by the Blue Shield Board, but have resulted from the physicians' own statement as to what their usual and customary fees have been. This information was obtained in a State-wide survey. In the meantime, physicians are updating their usual and customary fees when they fill in the current claim form. This information is being fed into a computor, and the profile of each physician's usual and customary fees is being established. If a physician's fee is above the mean for the State, he is paid up to one or two standard deviations above this fee depending on the circumstances, and following a formula developed by the Statistical Department of Blue Shield. In other words, the mechanism for paying usual and customary fees is based on a composite of the physician's own statement as to what these fees actually are.

In paragraph five, the inaccuracies are numerous. Blue Shield is paying no fees on the basis of usual and customary plus 30%. In Blue Shield's attempt to do away with income levels and fixed fee schedules, and at the same time offer some subsidy for the under income groups, eighty percent of the usual and customary fee will be paid to the under income group, and 95% of this same fee will be paid for those in the over income group.

In Paragraph six, he refers to a further expansion of Service Benefits to over income subscribers. Paying a usual and customary fee is not synonymous with the Service Benefit. It must be realized at this point that the Unions, Industry, and Government are demanding the delivery of medical services at a predictable cost. Furthermore, they are willing to pay an increased premium for such a contract.

A usual and customary fee schedule does imply some controlled ceiling as determined by the profession itself and it certainly is not an open-end fee schedule. Furthermore, it makes possible for Corporations and Government, who are paying 75% of the medical bill, to budget their medical costs. It is admitted that this will restrict the charges of a small percentage of physicians who in the past have charged fees four or five times larger than those of their colleagues practicing in a comparable area.

Paragraph seven is Dr. Susat's personal opinion based on an inaccurate premise.

In his last paragraph, he states that he hopes that the Executive Committee of your District Society will take the matter up. He might be interested to know that the Executive Committee of the State Society, acting as the Voting Members of Blue Shield, approved these new contracts.

The leadership of the Massachusetts Medical Society realizes that unless the medical profession voluntarily sets reasonable limits on their charges, there will be an increased pressure on the part of the Federal Government to set fee schedules under Medicare and Medicaid.

George R. Dunlop, M.D.
President
Mass. Medical Service

1967 vs. 1959

To the Editor:

At the HDMS meeting of December 5, 1967, the following resolution, submitted by the Executive Committee, was approved: "If an opinion regarding a controversial matter has been clearly expressed as a majority opinion by the District Medical Society, it is expected that our councilors note and act accordingly at the Council meeting."

It is interesting to note that in 1959, acting on a similarly worded amendment (but applicable expressly to the Executive Councilor), our Society voted to disapprove.

The late Dr. Fred Hagler, apparently quite happy over the 1959 action taken by The Society, submitted then the following item of correspondence in the May, 1959, issue of *The Hampden Hippocrat.* Dear Hippocrat: Apropos the recent problem of the Executive Councilor in representing our District Society, the following statement by Edmund Burke seems revelant: "Your representative owes you, not his industry only, but his judgment; and he betrays instead of serving you, if he sacrifices it to your opinion."

For the benefit of those too young to remember, Dr. Hagler, among other things, was a past president of the HDMS as well as of the Mass. Medical Society.

Max Millman, M.D.
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HIGHLIGHTS OF JANUARY MEETING OF THE EXECUTIVE COMMITTEE

The Executive Committee held its regular monthly meeting in the conference room of the HDMS on January 16, 1968. Present were: Drs. Baker, Griffin, Wiedman, Moore, Nero, Hough, Beauchamp, Jr., and Mrs. Purdy.

The minutes of the November meeting were read and approved. No meeting was held in December.

LETTERS

A letter regarding the chiropractic advertisement in a local newspaper was read. A response to the Committee's inquiries from David Wallwork, M.D., Secretary of the Mass. Board of Registration in Medicine and from Robert Youngerman, a staff associate at the AMA were read. The Mass. Secretary of Industrial Accidents was also contacted, and his answer was that services rendered by chiropractors would be considered reasonable and necessary medical services under the provision of the Massachusetts Workmens Compensation Act. No further action was taken by the Committee at this time.

A letter from the American Cancer Society regarding breast self examination was read. This is a project to be intensified in this area during the coming year and has the endorsement of the HDMS.

A letter from Mr. Harding J. Stewart of the Springfield Public Schools about family life and sex education was read. A curriculum is being set up for training people and teaching in this area. The names of interested physicians will be sent to the School Department upon request.

A letter from Dr. Susat regarding the recent literature from the Blue Cross office was read (see page 23).

COMMITTEE REPORTS

The following reply was received from Dr. Millman, Chairman of the By-Laws Committee, relative to a question raised at the September, 1967, meeting of the HDMS.

Question: "How about a real election of councilors at district level with one councilor for each specific twenty five physicians?"

Comment: "The procedure suggested in the above question conflicts in my opinion with the by-laws of the MMS. Section 2 of Chapter IV reads: The council shall consist of councilors chosen by the district societies —" It does not read, "— chosen by each 25 members of each district society —."

However, any member has the privilege of proposing an amendment to the District By-Laws provided it is done in accordance with Chapter VIII of our own by-laws. If he decides to do so, it is suggested that he indicate how the 25 members are to be selected; alphabetically, geographically, chronologically, etc. Before the amendment is brought to the floor, the District will have to check with the MMS to make sure that the proposed amendment is not in conflict with the by-laws of the MMS."

It was decided not to hold any special meeting on the Keogh Act as most physicians have been approached by individual solicitors.

The meeting was adjourned at 8:55 P.M.

The Grievance committee then met and considered several cases. Appropriate letters will be written. The meeting was adjourned at 9:20 P.M.

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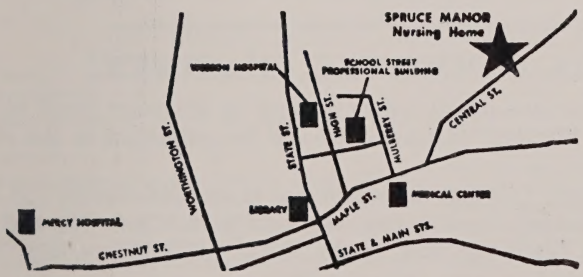

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MEETINGS

The following HDMS committees held meetings during January in the conference room of HDMS: Mental Health, Censors, Public Health, Pre-Council, Executive, Members Insurance, Hampden District Association Medical Assistants, Medico-Religious, Insurance, Labor Relations, Industrial Accident. A program on Alcoholism was held in the W.A.R. Chapin Auditorium at the Municipal Hospital. The second meeting of the Health Fair Committee was held.

SPEAKERS

Dr. Doering spoke at Mittineague School in West Springfield on "What to expect from Kindergarten through 13 Years Old."

Dr. Kennedy spoke at a meeting planned by the Western Mass. Heart Association on "Reduce Your Risk of Heart Attack."

Dr. Bernstein spoke at a meeting held at West Springfield High School on drug addiction.

Dr. Joan Brady spoke to the West Springfield Junior Women's Club on "Sex Education for Children."

"Time and Two Women" was the subject of an address by Dr. Siragusa at a meeting of Our Lady of Hope Guild.

Dr. Booker spoke at the Women's Division of the Joint Civic Agency on "Emergency Childbirth."

Dr. James Smith spoke to the Faolin Pierce Parent Teachers Association in Holyoke on the "Salute to Fathers Night."

Dr. Burkhardt participated in a panel on "Sex Education in the Elementary Schools" at a PTA meeting in South Hadley.

Dr. Tate was at Agawam Congregational Church with "Human Growth."

Dr. Carpenter addressed the VNA of Springfield on "Care of Mothers and Children."

Dr. Sanderson and Mrs. Purdy have been appointed to the Board of Directors of the VNA of Springfield.

RADIO

Dr. Kinsella was on radio WACE—"FOR YOUR INFORMATION."

ALSO Dr. Zadworny and Dr. Hoffman.

If you wish to be on radio, please call the office.

Dates open are: Feb. 16, Mar. 1, 15, and 29.

Have you any June issues of *The Hampden Hippocrat* that you don't want? Please, turn them over to the HDMS office if you have.

ATTENTION COMMITTEE CHAIRMEN!

Committee reports that are purely informational in character need not be presented at the Annual Meeting. Instead, they will be published in the April issue of the *Hippocrat.*

The only requirements are: (1) that the report not exceed 300 words; (2) that the original report reach Society headquarters not later than March 15; and (3) that a copy of the report reach the desk of the Editor-in-Chief not later than March 15.

Reports containing "recommendations" will have to be presented at the Annual Meeting.

Chairmen of sub-committees will not present reports at the Annual Meeting. They will instead report to their respective parent committees.

Your cooperation is urgently requested.

John F. Griffin, M.D., *Secretary*

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